All Wales Medicines Strategy Group

Grŵp Strategaeth Meddyginiaethau Cymru Gyfan

Persistent Pain Resources

Educational Slide Set

October 2016

This document has been prepared by a multiprofessional collaborative group, with support from the All Wales Prescribing Advisory Group (AWPAG) and the All Wales Therapeutics and Toxicology Centre (AWTTC), and has subsequently been endorsed by the All Wales Medicines Strategy Group (AWMSG).

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NHS WALES GIG CYMRU

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Management of Persistent Pain

AWTTC
All Wales Therapeutics & Toxicology Centre

Aims

Highlight the issues surrounding the management of persistent pain conditions and support patients, carers and healthcare teams in understanding the potential benefits and harms of medicines used in pain management.

Provide prescribers with the information needed to support the appropriate management of persistent pain conditions.

Highlight the risks associated with inappropriate prescribing of medicines in pain management.

Definitions

Pain

"Pain is an emotion experienced in the brain, it is not like touch, taste, sight, smell or hearing. It is categorised into Acute pain - less than twelve weeks duration and Chronic pain - of more than twelve weeks.

Pain can be perceived as a warning of potential damage, but can also be present when no actual harm is being done to the body."

British Pain Society
www.britishpainsociety.org/people-with-pain/useful-definitions-and-glossary/#pain

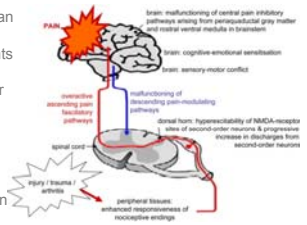
Neuropathic pain

"Neuropathic pain is pain initiated or caused by a primary lesion or dysfunction in the peripheral or central nervous system. For example, pain following shingles, or an amputation, or spinal cord trauma. Pain that occurs in diabetics or in patients with multiple sclerosis can also be neuropathic."

British Pain Society
www.britishpainsociety.org/people-with-pain/useful-definitions-and-glossary/#pain

Persistent Pain

- Persistent pain is complex and can be described as having both sensory and emotional components
- The only way of deciding whether someone has pain is by asking them or picking up clues from the way they behave
- There must be a patient-centred holistic approach to persistent pain management



Persistent Pain

Medicines in general and opioids in particular are often not very effective for persistent pain

Prescribers must consider the benefits for the patient balanced against the burdens and risks of long-term use

The position of opioid treatment must be considered within a wider social context, and issues such as diversion must be addressed

Different treatments work for different people

Managing expectations

Not likely to be cured

Not likely to be pain-free

Need to self-manage as with any other chronic condition

Patient needs to be party to the treatment and to take control/responsibility for some of their care

Background

Persistent pain is complex

Opioids are increasingly being used to treat persistent pain

Opioids have a well-established role in the management of acute pain and in the management of pain in terminal illness

However, the safety and efficacy of opioids in the long-term, as well as the risk of tolerance, dependence and addiction, is uncertain

Prescribers must consider the benefits for the patient balanced against the burdens and risks of long-term use

The position of opioid treatment must also be considered within a wider social context and issues such as diversion and misuse must be addressed


Ten Key Messages - Managing Persistent Pain

Non-pharmacological management of persistent pain

Non-pharmacological therapies and medicines with proven efficacy for persistent pain syndromes should always be tried before starting opioids


Ten Key Messages - Non-pharmacological Management

Self-management of persistent pain

It has been estimated that people with health conditions (including pain) may spend less than 3 hours a year on average in contact with members of their healthcare team; therefore, the need to learn self-management skills, as well as seeking the help of healthcare professionals, is very important.

Patients often feel helpless and unable to cope with pain themselves.

The Pain Toolkit is a very useful resource to set the scene with patients:

- Acceptance of the pain and recognition of the need to take control is an important part of self-management
- Goal setting, pacing, planning and prioritising daily activities help patients maintain motivation and increase their activity without causing significant fluctuations in pain levels
- Relaxation and mindfulness can help ease tension in the muscles and mind
- In some cases, lack of activity worsens deconditioning to the point where any movement becomes painful; patients should be encouraged to maintain a level of activity

Prescribing in persistent pain

Prescribing in pain management and opioids

Complete pain relief is rarely achieved with opioids; the goal of pain management should be to reduce symptoms sufficiently to support improvement in physical, social and emotional functioning

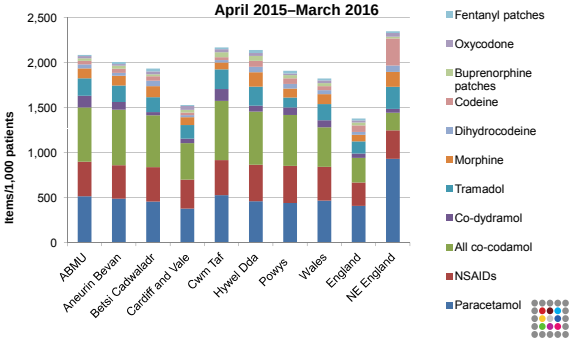
The decision to start long-term opioid therapy should be considered carefully by the patient and the prescriber, and arrangements for long-term monitoring must be in place

The prescribing of opioids can result in problem drug use and the likelihood of this occurring can be influenced by social, psychological and health related factors

Any concerns about problem drug use should prompt referral to specialised pain and addiction services

Resources should be available to prescribers in non-specialist settings to empower clinicians by supporting the evidence-based decisions they make within the complex context of multidisciplinary pain management

Opioid and other analgesic prescribing breakdown for health boards in Wales, England and NE England



Dose equivalences

The following slides provide examples from the BNF of dose equivalence tables of some commonly prescribed opioids

Equivalence tables may differ locally

Refer to local guidelines when appropriate

Equivalent doses of opioid analgesics

Analgesic	Route	Dose
Codeine	PO	100 mg
Diamorphine	IM, IV, SC	3 mg
Dihydrocodeine	PO	100 mg
Hydromorphone	PO	2 mg
Morphine	PO	10 mg
Morphine	IM, IV, SC	5 mg
Oxycodone	PO	6.6 mg
Tramadol	PO	100 mg

Fentanyl patch equivalences

72-hour fentanyl patches are *approximately* equivalent to the following 24-hour dose of oral morphine*.		
morphine salt 30 mg daily	≡	fentanyl '12' patch
morphine salt 60 mg daily	≡	fentanyl '25' patch
morphine salt 120 mg daily	≡	fentanyl '50' patch
morphine salt 180 mg daily	≡	fentanyl '75' patch
morphine salt 240 mg daily	≡	fentanyl '100' patch

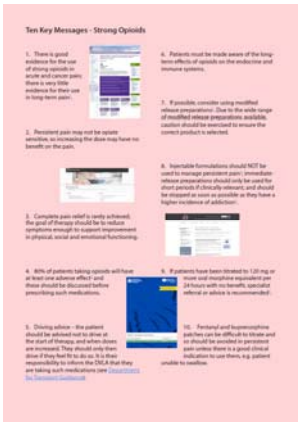
*Conversion ratios vary and these figures are a guide only. Morphine equivalences for transdermal opioid preparations have been approximated to allow comparison with available preparations of oral morphine.

Buprenorphine patch equivalences

Buprenorphine patches are *approximately* equivalent to the following 24-hour dose of oral morphine*.			
morphine salt 12 mg daily	≡	BuTrans® '5' patch	7-day patches
morphine salt 24 mg daily	≡	BuTrans® '10' patch	7-day patches
morphine salt 48 mg daily	≡	BuTrans® '20' patch	7-day patches
morphine salt 84 mg daily	≡	Transtec® '35' patch	4-day patches
morphine salt 126 mg daily	≡	Transtec® '52.5'	4-day patches
morphine salt 168 mg daily	≡	Transtec® '70' patch	4-day patches

*Conversion ratios vary and these figures are a guide only. Morphine equivalences for transdermal opioid preparations have been approximated to allow comparison with available preparations of oral morphine

Opioids



Strong Opioid Prescribing

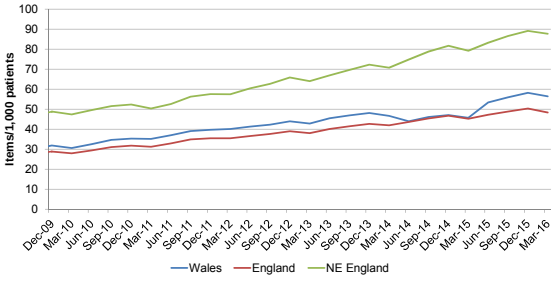
Strong opioid use a whole is increasing within NHS Wales

The number of prescription items of strong opioids in Wales has increased by **46%*** over the last few years

The number of prescription items for strong opioids increased by **11%** over the last year**

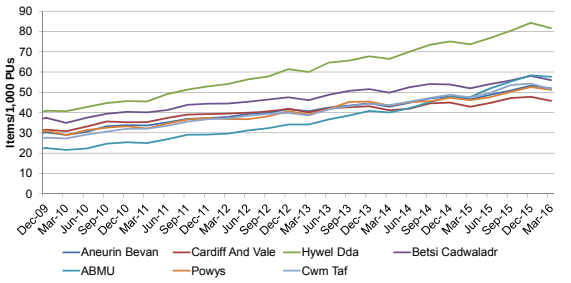
Strong opioid prescribing trends for Wales, England and NE England

Quarter ending December 2009–Quarter ending March 2016

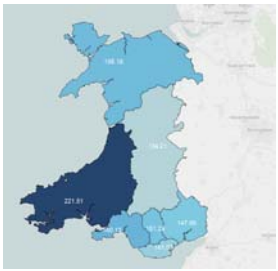


Strong opioid prescribing trends for Welsh health boards

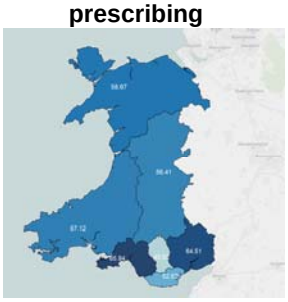
Quarter ending December 2009–Quarter ending March 2016



Strong Opioids – Items per 1,000 PUs



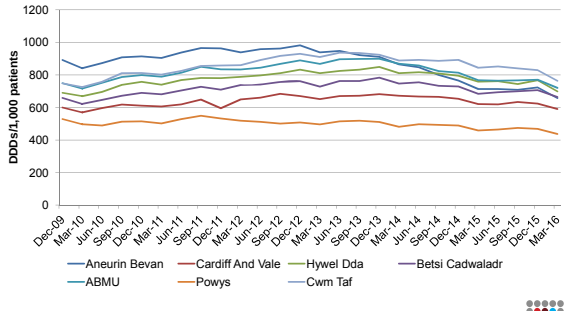
Morphine as a percentage of strong opioid prescribing



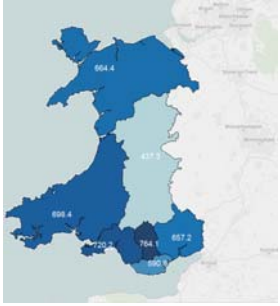
Tramadol

Tramadol prescribing trends for Welsh health boards

Quarter ending December 2009–Quarter ending March 2016



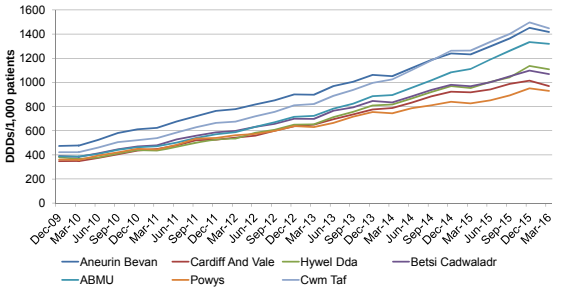
Tramadol – DDDs per 1,000 patients



Neuropathic agents

Gabapentin and pregabalin prescribing trend for Welsh health boards

Quarter ending December 2009–Quarter ending March 2016



National Prescribing Indicators

NPIs

2015-2016

Items of morphine as a percentage of strong opioid prescribing

Tramadol DDDs per 1,000 patients

2016-2017

Tramadol DDDs per 1,000 patients

Gabapentin and pregabalin DDDs per 1,000 patients

SPIRA

Online interactive programme for comparative analysis of NPI information

Available at http://howis.wales.nhs.uk/sites3/page.cfm?orgid=428&pid=69110

Information relating to harm

ONS
NPIS
YCC

Deaths related to drug poisoning in England and Wales 2014

3,346 drug poisoning deaths were registered in 2014 in England and Wales, the highest since comparable records began in 1993

Deaths involving heroin and/or morphine increased by almost two-thirds between 2012 and 2014, from **579** to **952** deaths

Deaths involving tramadol have continued to rise, with **240** deaths in 2014

In England there was a **17% rise** in the drug misuse mortality rate in 2014 to **39.7** per million population, while in Wales the rate **fell** by **16%** to **39.0** deaths per million, the lowest since 2006

Number of drug-related deaths in England and Wales by substance

	2010	2011	2012	2013	2014
All drug poisoning deaths	2,747	2,652	2,597	2,955	3,346
Heroin and morphine	791	596	579	765	952
Methadone	355	486	414	429	394
All amphetamines	56	62	97	120	151
MDMA/Ecstasy	8	13	31	43	50
PMA/PMMA	0	1	20	29	24
Novel psychoactive substances	22	29	52	60	67
All benzodiazepines	307	293	284	342	372
Diazepam	186	179	207	228	258
Zopiclone/zolpidem	67	71	83	86	100
All antidepressants	381	393	468	466	517
Tricyclic antidepressants (BNF 4.3.1)	194	200	233	235	253
Selective serotonin re-uptake inhibitors (SSRIs) (BNF 4.3.3)	136	127	158	150	159
Other antidepressants (BNF 4.3.2 and 4.3.4)	74	84	104	123	155
Paracetamol	199	207	182	226	200
Tramadol	132	154	175	220	240
Codeine	91	88	73	130	136
Dihydrocodeine	90	109	103	102	86
Other specified opiate	66	90	80	93	129
Unspecified opiate	172	131	92	145	169

Telephone enquiries to the National Poisons Information Service (NPIS) 2014–2015

Substance	Number of telephone enquires	Ranked
Tramadol	659	8
Morphine	248	20
Gabapentin	278	31
Pregabalin	435	18
Methadone	74	N/A

Thank you

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